	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr Bruno Holthof, Chief Executive, Oxford University Hospitals NHS Foundation Trust**
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION AND INQUEST** On 5 September 2018 I conducted the inquest into the death of Marian Grant at Oxford Coroner's Court. My Conclusion was one of 'Accident' and I made the following finding: *'Marian Grant tripped and fell at Magdalen Park, Oxford at approximately 16.30 hours on 14 April 2018. She was assessed but not given DVT prophylaxis and succumbed to a Pulmonary Embolism at the beginning of the operation on 16 April 2018 to replace the fractured hip.'* The Trust were legally represented at the inquest. In addition to written evidence submitted by the Trust, there was oral evidence from [redacted] (Consultant Anaesthetist), [redacted] (Consultant Trauma and Orthopaedic Surgeon) and [redacted] concerning the RCA Investigation Report. Members of Mrs Grants family, including her son, attended the inquest and asked questions of witnesses. They were understandably concerned about the failure to provide VTE prophylaxis and the extent to which this contributed to Mrs Grants demise. I have not provided you with a full copy of the inquest file because one is held by your Legal Services Department.
4	**CIRCUMSTANCES OF THE DEATH** As set out above, Marian Grant aged 74 tripped and fell on 14 April. Along with other family, she was visiting her grandson at university. She was an active lady, relatively fit, and still working as a care assistant prior to her death. She was transported by ambulance to the John Radcliffe Hospital. The initial plan was that she would undergo surgery on the following day, Sunday, but there were other urgent cases which took priority and therefore the surgery took place first thing on Monday 16 April. Unfortunately, she died intra-operatively with a medical cause of death provided by [redacted] of: 1a Pulmonary Embolism 1b Deep Vein Thrombosis 1c Fractured Neck of Femur

	[redacted] commented that there was a massive pulmonary embolism from deep vein thrombosis in both legs and that the most likely underlying risk factor for the DVT was immobilisation following the femoral fracture. He also referred to histology showing that there were multiple marrow emboli in pulmonary arteries in addition to fresh thrombo emboli and that the marrow emboli was in keeping with the recent fracture and likely to have exacerbated the cardio vascular consequence of thrombo embolism.
5	**CORONER'S CONCERNS** **During the course of the Inquest the evidence revealed matters giving rise to concerns. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to make this report to you.** I appreciate there has been an RCA Investigation and an Action Plan. I was provided with an updated copy of the Action Plan and it is reassuring to note that several measures have been undertaken to reduce the risk of a similar incident occurring in future. I note that the RCA Report states that the Root Cause was 'Omission to prescribe chemical or mechanical VTE prophylaxis because of technical difficulties with EPR. This omission was not resolved at a later date.' The report goes on to say this incident is classified as an avoidable VTE event and that this is therefore an avoidable death by definition and that the failure to provide any prophylaxis meant that the risk of a fatal PE must have been increased. I heard evidence about a number of checks and fail-safe procedures. I refer to two in particular. The first concerned the training, experience and knowledge of nursing staff on the trauma wards who are very familiar with the requirements for VTE prophylaxis and a tendency for the nurses to pick up and deal with any omissions in this regard. The second check is the EPR alerts. The **MATTERS OF CONCERN** are as follows: 1. The first concern relates to what are referred to as 'outlying patients'. Mrs Grant went from the emergency department to a neuro-science ward because there were no beds on a trauma ward. It appears that her placement on a ward other than a trauma ward raised issues in respect of her care and, in particular, it meant she was not being cared for by trauma nurses who might ordinarily be expected to pick up the omission concerning VTE prophylaxis. I understand it is relatively common for a trauma patient to be placed on a ward other than a trauma ward. I understand that this may be unavoidable but I am concerned about there being sufficient safeguards in place. I see from the Action Plan that recommendations 1 and 7 refer to this issue. There has been an audit and the trauma co-ordinator is to check VTE prophylaxis has been prescribed to trauma patients outlying on non-trauma wards. I seek reassurance that the audit of care for such patients confirms that the same standard of care is delivered regardless of location. I also seek information and reassurance about the practical steps taken by the trauma co-ordinator to check VTE prophylaxis. There were a number of system checks which failed in this case and it is therefore important that system checks are effective.

	2. The second concern relates to ignoring the VTE prophylaxis alerts on EPR. I note from the RCA Report that the warning was visible on exiting the record by all staff. [redacted] explained however that often the warning would not be seen because sometimes a doctor does not actually exit the record but keeps it open (albeit secure). It is surprising that from the time of transfer to the neuro-science ward from ED until the time when the patient was seen by the Consultant Anaesthetist [redacted] on the morning of surgery on 16 April that the EPR was accessed 27 times by staff members and yet none of the staff interviewed recalled seeing the alert. A system designed with fail-safes in the form of alerts is obviously not effective if the alerts are not seen or routinely ignored. Recommendation 8 on the Action Plan refers to this issue and I see that an email has been sent out to the EPR Lead and that a new version of EPR will prevent staff being able to exit the EPR record until VTE alerts have been dealt with. As mentioned, it seems though that doctors do not always exit the record and, as I understand it, the alert will not pop up unless the record is being exited. It would be appreciated if you could provide some clarification on this and also address the wider issue of alerts not being acted upon.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. I may extend the period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I confirm that a copy of this report and your response will be sent to Mrs Grant's family. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Signed** **Date** 11th September 2015 **Mr D.M. Salter** **HM Senior Coroner for Oxfordshire**